Increasing California's Capacity to Effectively Serve Individuals in Mental Health Crisis

CBHDA Governing Board Policy Brief — November 2015

The Challenge

CBHDA Members ranked as the #1 leadership and advocacy priority for the coming year the need for the Association to focus on increasing California's capacity to effectively serve individuals in mental health crisis. The two related goals members reported are expanding the *types* of available crisis services, as well as the supports needed *after* a crisis is stabilized. In California, county mental/behavioral health departments provide an array of crisis and psychiatric inpatient care services to Medi-Cal beneficiaries who meet medical necessity criteria, individuals who are a danger to themselves or others due to a mental disorder, and others to the extent resources are available. As pre-paid inpatient health plans, county Mental Health Plans must provide inpatient and post stabilization care, and disposition from hospital emergency rooms to enrollees. However, due to a range of challenges, counties, consumers, and families report the availability of crisis and inpatient mental health services is lacking throughout the state. Hospitals, law enforcement, and the courts are also concerned that a lack of adequate crisis and inpatient care leads far too many individuals to visit hospital emergency departments or find themselves arrested and in jail. For youth, older adults, individuals with serious substance use disorders, and individuals with significant medical conditions or disabilities, appropriate crisis and inpatient services are even more limited.

In the 2012 California Mental Health and Substance Use System Needs Assessment submitted to the CA Department of Health Care Services, the Technical Assistance Collaborative and Human Services Research Institute (HRSI) estimate the appropriate number of adult psychiatric beds in a "mature well-managed mental health system" should be in the range of 18 to 22 beds per 100,000 adults. However, the California Hospital Association, citing the Treatment Advocacy Center, estimates the goal to be more than double this amount – 50 per 100,000 residents. Based on 2010 census data, California's adult (over age 18) population is 27,958,916. Therefore, in order to reach the Technical Assistance Collaborative/HRSI goal of 18 to 22 inpatient beds per 100,000 adults, California would need to have between 5,032 and 6,138 adult acute inpatient beds. To reach the Treatment Advocacy Center goal, we would need 13,950 beds. According to 2012 OSHPD data, California currently has 5,522 adult acute care inpatient psychiatric beds.

Some of the specific challenges contributing to the lack of crisis and inpatient care capacity include:

- **The federal IMD exclusion.** Originally designed to ensure states were fully responsible for the care of the many individuals who used to receive psychiatric care in large hospitals, asylums, and institutions, the federal Medicaid Institution for Mental Disease (IMD) exclusion prohibits states from receiving federal Medicaid matching funds for inpatient services they provide to adult (18-65) Medicaid enrollees in a hospital, nursing home, or other inpatient care setting with more than 16 beds. This outdated federal policy

makes it very difficult for nursing facility operators to establish sites of 16 beds or fewer, due to the economy of scale.

- **Limited public financial resources available for adult psychiatric inpatient care.** Counties receive 2011 Realignment funds for their provision of both inpatient and outpatient Medi-Cal Specialty Mental Health services. However, due to the IMD exclusion, these state sales tax revenue funds may not be used to draw down federal Medicaid matching funds if inpatient services are provided in a setting of 17 beds or larger. While Mental Health Services Act (MHSA) service recipients may require inpatient care at times, MHSA funds may not be used to provide for their inpatient care. This leaves 1991 Realignment funds and, in some communities, county General Funds. However, until statutory changes were recently made to the 1991 Realignment funding for mental health, counties received essentially flat funding and no growth funding for their 1991 Realignment mental health responsibilities (i.e., IMD, civil commitments in state hospitals, and community mental health).
- **Stigma and discrimination.** Due to negative attitudes and myths about the dangerousness of people with mental illness, counties and providers often face substantial community opposition when attempting to construct or repurpose a facility intended to be used for individuals in psychiatric crisis or in need of inpatient care.
- **Disinvestment in acute psychiatric care and competing demands on hospitals.** According to a recent report by the California Health Care Foundation, skilled nursing and acute psychiatric beds have declined significantly in the last decade, as hospitals focused more on general acute care services, including both adult and newborn intensive care capacity. Overall, the use of hospital emergency departments in California has risen by 19%, compared to just 11% for the US as a whole.

Existing Resources and Efforts

Current resources and recent related efforts include, but are not limited to:

- California's Medicaid State Plan Amendment for Rehabilitative Mental Health Services includes the covered services below to all beneficiaries who meet medical necessity criteria. County mental health plans use 1991 and 2011 Realignment, Mental Health Services Act, and federal Medicaid reimbursement
    - **Crisis Intervention**, which can be provided in a community or clinical treatment setting, to enable a beneficiary to cope with a crisis and regain status as a functioning community member.
    - **Crisis Stabilization**, which must be provided at a licensed 24-hour health facility or hospital and may last up to 24 hours, to address an urgent condition and avoid the need for inpatient services.
    - **Crisis Residential Treatment Services**, which provides a structured program for up to 3 months as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care.
    - **Adult Residential Treatment Services**, which are non-institutional, residential settings, to help avoid hospitalization or other institutional placement, help beneficiaries with interpersonal and independent living skills, and help with access to community supports.
    - **Psychiatric Inpatient Hospital Services**, which are both acute psychiatric inpatient hospital services and administrative day services provided in a hospital. These

facilities include: a) Psychiatric Health Facilities; b) free-standing acute psychiatric inpatient hospitals; and c) psychiatric units within general acute care hospitals. Note: The IMD exclusion applies for these facilities if they have more than 16 beds.

- The Investment of Mental Health Wellness Act (SB 82), which has so far funded additional Crisis Residential (796 beds); Crisis Stabilization (149 beds); and Mobile Crisis services (48 vehicles and 58 staff). Additionally, by 2016-17, it is estimated that 490 triage personnel will be funded statewide.
- Congress established the Medicaid Emergency Psychiatric Demonstration Program in 2010 to test whether allowing federal Medicaid matching payments to freestanding psychiatric hospitals for emergency psychiatric cases would improve the quality of, and access to, care and reduce Medicaid program costs. The demonstration, which is set to terminate on December 31, 2015, has provided up to $75 million over three years to enable IMDs in 11 states (including California) and the District of Columbia to receive Medicaid reimbursement for treatment of patients aged 21 to 64 who require treatment for psychiatric emergencies. Preliminary data indicate that allowing such coverage is reducing utilization and lowering costs.
- The Mental Health Services Oversight & Accountability Commission is undertaking an effort to document the current state of crisis services for children and youth throughout California and identify recommendations for improvement. A report is planned to the full Commission in early 2016.
- The California Hospital Association, Psychiatric Association, and American College of Emergency Physicians are pursing changes to involuntary commitment statutes, including permitting emergency room physicians to release holds and establishing statutory requirements for facilities that are “non-designated.”